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Nos. 02-1845 and 03-83

IN THE

Supreme Court of the United States

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC. and CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICUS CURIAE HEALTH ADMINISTRATION RESPONSIBILITY PROJECT IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICUS CURIAE

This brief is respectfully submitted on behalf of amicus curiae Health Administration Responsibility Project.[1] The interests of the amicus curiae is as follows:

Health Administration Responsibility Project (HARP) is a non-profit organization that serves as an educational and informational resource for patients, doctors, and attorneys regarding managed care organizations, and seeks to enhance the quality of medical care benefits provided in the managed care setting. Because these cases implicate a statutory remedy scheme for an HMO's failure to exercise due care in the rendition of medical services similar to that established under California law (Civil Code section 3428), HARP has an immediate interest in assuring that such protections remain viable and enforceable.

SUMMARY OF ARGUMENT

The major, and perhaps the only, real question affecting the implementation of the Texas Health Care Liability Act ("THCLA") (Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003) against the insurer defendants in these cases, is whether Congress intended to deprive employee plan beneficiaries of non-ERISA remedies as against defendants who are not employee plans and who are thus not regulated by ERISA.

The Federal judicial preemption of state remedies for insurance company malfeasance has allowed ERISA to evolve into a shield that insulates insurers doing business with employee plans from liability for even the most egregious derelictions committed against the very plan beneficiaries that ERISA was intended and designed to protect. (*cf*: *DeFelice v. Aetna*, Third Circuit No. 02-3381 (2003), Baxter Concurrence)

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1. Petitioners and Respondents have filed blanket consents to the submission of amicus briefs with this Court. Pursuant to Rule 37.6, Amicus discloses that no counsel for a party authored any part of this brief, nor did any person or entity other than Amicus Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

Aetna blatantly exploits this immunity, to the detriment of ERISA enrollees, as shown in their training videotape for claims managers, entered in evidence in a prior case, *Fisher v. Aetna Life Insurance Co.*, No. 3AN97-291, Alaska Super., Anchorage (1998). In that video, the Aetna instructors tell the claims managers that they should just deny ERISA claims without investigation, since there is no liability for bad-faith damages. But with respect to non-ERISA cases, they must be carefully investigated because of the risk of potential bad faith and punitive damages liability. (See: "Aetna video fuels renewed HMO fight" by Laura Meckler, *Associated Press*, October 13, 1998; Tale of Aetna tape: fear of suit a factor in health claim reviews" by Daniel M. Weintraub, *The Orange County Register*, October 25, 1998, News, pg. A 04; "Law Keeps Many Patients From Suing Health Insurers" by Jane Bryant Quinn, *Seattle Post-Intelligencer*, November 24, 1998, Business, pg. C1.) This dichotomy in claims handling exemplifies the need to restrict the application of ERISA preemption to the entities ERISA was designed to regulate – the plans, not contractors to the plans.

The statute at issue in these cases, the THCLA, was specifically designed to impose some measure of control over such injurious practices of insurers – not plans.

As the Fifth Circuit has effectively demonstrated in the opinions being appealed, the THCLA exclusively regulates insurance, and thus falls under the protection of ERISA's saving clause, 29 U.S.C. § 1144. As such, it is not subject to field preemption. Nor does the statute interfere with any of the remedies of ERISA. As such it is not subject to conflict preemption.

Thus the only remaining issue regarding the applicability of THCLA to the insurers in these cases is whether ERISA's equitable remedies were intended to be "exclusive" as against **non-plan** defendants. The letter of ERISA, and its legislative history, demonstrate that they were not.

The best way to satisfy explicit Congressional intent while adhering to the strict language of the law is to define the scope of ERISA as applying to the **insurance coverage** paid for by **the plan**, not **the medical service** paid for **by the insurer**. Only the failure to provide that insurance coverage should be a violation subjecting the plan to the remedies of § 502(a). The insurer's failure to pay for or provide specific medical service should subject the insurer to state contract and tort remedies, since ERISA provides no federal jurisdiction over such non-plan entities.

LEGAL ARGUMENT

1. CONGRESS DID NOT INTEND TO LIMIT THE REMEDIES OF ERISA BENEFICIARIES AGAINST NON-PLAN DEFENDANTS

Where "federal law is said to bar state action in fields of traditional state regulation . . . we have worked on the 'assumption that **the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.**'" (*New York State Conf. Of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995); emphasis added.)

In ERISA, Congress manifested its purpose to: **"protect . . . participants in employee benefit plans and their beneficiaries"** (29 U.S.C. § 1001(b); emphasis added.)

This Congressional intent was further clarified by Rep. Perkins during the House debate of August 20, 1974 on the final conference report:

> . . . the purpose of this conference report is relatively simple. It is designed to reduce sharply the number of people who pay money into private pension plans year after year expecting eventually to receive retirement income, only to have their hopes dashed and end up getting nothing.

(Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess ("Leg. Hist.") p.4657).

As with so much of ERISA, this comment is directed at the pension aspect rather than the welfare aspect of the bill, but the application to health plans is obvious. The bill was designed to see that beneficiaries get what they're entitled to, not to put obstacles in their path.

Congress nowhere said in the bill, in the conference reports, or in the floor debates, that it intended to protect employers or employee benefit plans for their own sake. It most assuredly did not assert an intention to protect from state tort or contract remedies any third party that happened to do business with a benefit plan. Nor did it assert any intention to lower health care costs by encouraging insurers to deny needed medical care through immunity from liability. That is a recently-appearing political issue with which the courts should not become embroiled.

In fact, the savings clause itself makes clear that ERISA's preemption clause was not intended to protect insurers who sold coverage to employee benefit plans. ERISA's preemption provision, section 514(b)(2)(A), codified at 29 U.S.C. § 1144(b)(2)(A), explicitly provides that "*nothing in this subchapter* shall be construed to exempt or relieve any person from *any* law of any State which regulates insurance, banking or securities." (Emphasis added.) The subchapter referenced in that subdivision, *includes ERISA's remedies provisions,* i.e., ERISA section 502, 29 U.S.C. § 1132. Congress said it very plainly: *Nothing* in the subchapter – including the remedies provision – can be construed to exempt insurers from state law regulation. That must, therefore, necessarily include state laws regulating the remedies imposed on insurers.

Nor does this do any harm to Congress's intent to provide administrative protection to ERISA plans. As this Court acknowledged in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), there is a distinction – and properly so – between ERISA plans themselves and the insurance protection they buy. Allowing state laws to impose different remedies against *insurance companies* when *insurance companies* violate state insurance law does

nothing to thwart Congress's intent to protect the administrative regulation of the plan itself.

In view of Congress' single-minded purpose of protecting plan beneficiaries, it is unreasonable to infer that it would enact a blanket preemption simply because it wanted to prevent beneficiaries from being fully compensated for their injuries, to the benefit only of unscrupulous third-party tortfeasors. The only consistent rationale for ERISA's preemption provisions is to preserve the assets of the employee benefit plans so they could be used for the benefit of all enrollees. However, a suit against an HMO or insurance company contractor of an insured benefit plan obviously does not threaten the **plan's** assets. The only interpretation compatible with the purposes of ERISA is that if the remedies of § 502 were intended to be the "exclusive remedy", they were intended to be exclusive **only** as against the plan, not the producer of the product sold to the plan. The plan is the only entity regulated by ERISA, and the only one whose assets Congress was anxious to preserve for the benefit of other beneficiaries.

Thus, to be consistent with expressed congressional intent, ERISA should not be interpreted so as to sacrifice the interests of beneficiaries to the competing interests of third-party insurers.

Claims have been made that preemption is necessary to encourage the formation of employee benefit plans. But there has never been any indication of how allowing beneficiaries to recover from unrelated third parties would "discourage" the formation of benefit plans. This argument clearly has no force.

If the beneficiary sues an independent risk-bearing insurer, and if there is any effect on the plan's assets at all, it would be indirect. If the insurer raises its rates because of litigation losses, the plan has the choice of remaining with that insurer, or switching to an insurer which acts reasonably and, as such, doesn't incur those litigation losses. This Court has already stated that such indirect effects do not implicate ERISA preemption. (*Travelers*, 514 U.S. 645, 659) And in *De Buono v. NYSA-ILA Med. and Clinical Servs.*, 520 U.S. 806, 815, 117 S. Ct. 1747, 138 L. Ed. 2d 21 (1997) this Court went even further, stating

that "myriad state laws" of general applicability that impose even direct burdens on the administration of ERISA plans nevertheless do not necessarily "relate to" them within the meaning of ERISA. "Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is preempted by the federal statute." (*Ibid*, p.816)

This Court in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 57 (1987) explicitly refused to support the proposition that an insurer inherits the protection that an employee benefit plan might be entitled to if it were acting on its own:

> Footnote 4: "Because we conclude that Dedeaux's state common law claims fall under the ERISA pre-emption clause and are not rescued by the saving clause, **we need not reach Pilot's argument that when an insurance company is engaged in the processing and review of claims for benefits under an employee benefit plan, it is acting in place of the plan's trustees and should be protected from direct state regulation by the deemer clause."**

(Emphasis added)

An insurer might make the "agency" argument if it were solely a non-risk-bearing administrator of the benefit plan, and the benefit plan itself was at risk for the damages. But if the benefit plan merely paid insurance premiums, and the insurer was the only party at financial risk, Congress would have had no reason to frustrate ERISA's basic purpose of protecting beneficiaries, or to put them in a far worse legal position than those who do not have the "benefit" of federal "protection".

Rep. Perkins admitted on the House floor that: "On a bill so vastly complicated some consequences are almost certainly unforeseen and some problems will arise . . ." (Leg. Hist. p.4685) This argues against the frequently-expressed view that ERISA

is so "finely crafted" that its words must be taken literally, even when doing so subverts the expressed purpose of the bill.

One of the greatest problems with the bill is that its drafters were focused almost entirely on abuses of **pension** plans, and welfare benefit plans were tacked on almost as an afterthought. This is apparent throughout the floor debates as well as in the bill itself. All of the "horror stories" offered by proponents to support passage of the bill were related to losses of pension benefits. There is no reference to loss of medical benefits in the 5319 pages of legislative history. Thus equitable remedies, which might be entirely satisfactory to a person denied only monetary pension payments, should not be assumed to be intended as the sole remedy for someone who has suffered injury or death due to negligent or intentional denial of needed medical benefits – a remedy that has proven to be entirely inadequate. (*See, e.g.*, *Jordan v. Reliable Life Ins. Co.*, 694 F. Supp. 822, 827 (1988); *Olson v. General Dynamics* 960 F.2d 1418, ¶27 (9th Cir. 1991), concurring opinion; *Dishman v. Unum*, DC# CV-96-00015-JSL (C.D. CA 1997); *Andrews-Clarke v. Travelers Insur. Co., et al.*, 984 F. Supp. 49, 52 *et seq.* (1997).)

To the extent compatible with the literal meaning of the law, ERISA should be interpreted to protect beneficiaries denied medical care by HMOs, and not to restrict them to remedies appropriate only for denial of pension benefits, or denial of insurance coverage by a plan.

2. SUITS AGAINST HMOS SHOULD BE SUBJECT TO THE PREEMPTION PROVISIONS OF THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973, NOT THOSE OF ERISA

Davila and Calad are suing HMOs, not employee benefit plans. In addition to the fact that ERISA's preemption clause specifically saves from preemption actions against insurers, even as to state remedy schemes, Congress also explicitly delineated the scope of federal preemption for HMOs. The very same Congress that passed ERISA passed the HMO Act of 1973 only a few months before. That Act's very moderate preemption

section (42 U.S.C. § 300e-10) is quoted in full below, explicitly stating the degree of preemption to be applied to state laws affecting HMOs. **This** is the appropriate preemption provision to be applied to suits against HMOs, **not** that in ERISA.

> Sec. 300e-10. – Restrictive State laws and practices
>
> (a) Entities operating as health maintenance organizations
>
> In the case of any entity –
>
> (1) which **cannot do business as a health maintenance organization** in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise –
>
> (A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,
>
> (B) requires that physicians constitute all or a percentage of its governing body,
>
> (C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,
>
> (D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, or
>
> (E) imposes requirements which would prohibit the entity from complying with the requirements of this subchapter, **and**
>
> (2) for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees'

health benefits plans), **such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 300e of this title.**

(b) Advertising

No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this subchapter or which is a qualified health maintenance organization for purposes of section 300e-9 of this title (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgement concerning, any health professional who provides services for a health maintenance organization.

(c) Digest of State laws, regulations, and practices; legal consultative assistance

The Secretary shall, within 6 months after October 8, 1976, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least annually and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purpose of complying with the provisions of this section.

With the passage of this very moderate preemption clause fresh in their minds, it is inconceivable that those who passed it would intend to override it the very next year of the same congressional session, without expressly saying so.

3. LEGISLATIVE HISTORY DEMONSTRATES THAT THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973 WAS ALSO THE MODEL FOR ERISA PREEMPTION

Even if the preemption provisions of ERISA **are** determined to apply to HMOs when they do business with employee benefit plans, those ERISA provisions should be interpreted in the light of the relatively moderate HMO Act of 1973.

This Court stated in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983):

> The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language.
>
> See H.R. Conf. Rep. No. 93-1280, p.383 (1974); S. Conf. Rep. No. 93-1090, p.383 (1974).

However, that Conference Committee Report actually gave no explanation whatever for the change from the language of the bills passed by both houses, nor any suggestion that the omission was even intentional. It made no reference at all to the prior versions. All it did was restate the final statutory language in a more conversational format. It is not at all clear that a substantive change was intended. (Leg. Hist. p.4650)

Representative Dent, the House sponsor of the bill, in an oft-quoted oratorical flourish, described the "reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans" as "what to many is the crowning achievement." of ERISA. 120 Congr. Rec. 29197 (1974).

However, he then went on to say:

> . . . **we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation**. [n.b.: conflict preemption, not complete preemption]. **We followed to a large extent the same approach as in Public Law 93-222, 87 statute (414) where the regulation of health maintenance organizations was foreclosed to State authority-section 113(a).**

(Emphasis added) (Leg. Hist. p.4670)

So we can discern how the ERISA Congress intended preemption to protect participants, by looking at the preemption section of the HMO Act of 1973 (P.L. 93-222) that Rep. Dent referred to, which is codified, unamended, at 42 U.S.C. § 300e-10, and reproduced in full above. This section, **the declared model for ERISA preemption**, is seen to mandate only a very limited form of conflict preemption.

The contrast between the extremely cautious and narrowly-targeted preemption provisions of the HMO Act, affecting **only** state laws which might prevent an HMO from doing business, and the oppressively ruthless preemption of ERISA as currently applied, for which the former served as a model, is dramatic. It is clear that the current scorched-earth interpretation of preemption is far from the intentions of the drafters.

Senator Williams, the Senate sponsor of the bill, said:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus **eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans**. This principle is intended to apply in its broadest sense to all actions of State or local governments, or

> any instrumentality thereof, which have the force or effect of law.

(Leg. Hist. 4745-46)

He too, though using the term "field", demonstrates that he really intended "conflict preemption".

The last sentence in the above quote is clearly not designed to preempt all State tort and contract law, but to eliminate **only conflicting regulation** by any instrumentality of State or local government, e.g. Medical Boards and Bar Associations, as the subsequent comments of Sen. Javits with respect to legal service plans make clear:

> Section 514 of the act does not preempt State bar associations from adopting and enforcing ethical rules or guidelines generally and/or from disciplining its members . . . But the State, directly or indirectly through the bar, is preempted from regulating the form and content of a legal service plan . . . in the guise of disciplinary or ethical rules or proceedings.

(Leg. Hist. p.4789)

The ERISA drafters speak only about State **regulation of employee benefit plans**, never about non-plan entities, and in particular, never about tort or contract law as applied to non-plan entities by beneficiaries. The expansiveness of the language above refers to all possible regulators of plans, not all possible laws, and not all possible defendants.

Sen. Javits also appeared to intend that the bill mandated only **conflict** preemption: "In view of Federal preemption, **State laws compelling disclosure . . . , imposing fiduciary requirements . . . , imposing criminal penalties on failure to contribute . . . , establishing State termination insurance programs, etc., will be superseded**." (Leg. Hist p.4771) (Emphasis added.)

We thus see the kinds of laws that Congress intended to preempt. There is nothing about protecting individual or

corporate tortfeasors employed by or contracting with an employee benefit plan. By the principle of *ejusdem generis*, it should be concluded that preemption was intended to apply only to state regulations of the sort specified by Sen. Javits, Sen. Williams, and Rep. Dent .

4. LEGISLATIVE HISTORY DEMONSTRATES THAT THE MODEL FOR ERISA PREEMPTION WAS NOT THE LABOR MANAGEMENT RELATION ACT

What then is to be made of the claim, asserted throughout *Pilot Life*, 481 U.S. 41, 52 *et seq.*, that ERISA preemption was based on the severe preemption provisions of § 301 of the Labor-Management Relations Act of 1947? Respectfully, that is not an accurate assertion, based on ERISA's legislative history.

The Conference Report on ERISA describing the civil enforcement provisions of § 502(a) says:

> . . . With respect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the Title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. **All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947.**

H.R. Conf. Rep. No. 93-1280, p.327 (1974) (emphasis added). (Leg. Hist. p.4593, last paragraph)

This section says **nothing** about preemption. It refers to the LMRA **only** to exemplify the combined Federal-State jurisdiction over federal civil claims. Indeed, the conference report never mentioned the preemptive force of § 301, and referred to it only for this jurisdictional analogy.

The **only** federal law ever referred to anywhere in the legislative history as a model for the **preemption** portion of

ERISA, is the HMO Act of 1973, passed by this same Congress, and which imposes a very **weak** conflict preemption.

> On numerous occasions we have noted that "in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy."

(*Pilot Life v Dedeaux*, 481 U.S. 41, 51 (1987), quoting ultimately *United States v. Heirs of Boisdore*, 8 How. 113, 122 (1849).)

And the "object and policy" of ERISA is to increase the protection of workers against the schemes of predatory employers and insurers. How does stripping them of rights, which don't deplete the plan's fund, achieve that end? Shall that essential purpose of ERISA be frustrated and even turned on its head by a misunderstanding of a single comment made in a conference report?

5. STATE LAWS AFFECTING ONLY INSURERS AND NOT EMPLOYEE BENEFIT PLANS DO NOT NEED TO BE SAVED BY § 514(b)(2)(A) SINCE THEY DO NOT 'RELATE TO' AN EMPLOYEE BENEFIT PLAN WITHIN THE MEANING OF ERISA IN THE FIRST PLACE

In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), a Massachusetts statute required certain mental health care benefits in general health insurance policies. The Court concluded, first, (p.739) that the Massachusetts statute did "relate to . . . employee benefit plan[s]," thus placing the state statute within the broad sweep of the pre-emption clause, § 514(a). However, the Court then held that, because the state statute was one that "regulate[d] insurance," the saving clause prevented the state law from being pre-empted. (guided by the McCarran-Ferguson Act).

Though the result is surely correct, the reasoning cannot be. If an employee benefit plan or its insurer hired a doctor, and the State required that the doctor be licensed by a medical board,

the logic of *Metropolitan Life* would say that this "relates to" the employee benefit plan for the same reason that regulation of an insurer which contracts with an employee benefit plan "relates to" such plans. But a doctor licensure law will not be saved under the insurance saving clause, since it does not regulate insurance, so, by the logic of *Metropolitan Life* it would have to be concluded that medical licensure laws are preempted and employee benefit plans and their contracting HMOs are free to hire non-licensed persons to give medical care. But this is absurd, and surely not what Congress or this Court would intend. So the major premise, that State regulation of non-plan entities which contract with plans automatically "relates to" employee benefit plans, must be rejected.

Similarly, *Pilot Life* stated in dictum: "There is no dispute that the common law causes of action asserted in Dedeaux's complaint [against an insurer of an employee benefit plan] "relate to" an employee benefit plan and therefore fall under ERISA's express pre-emption clause, § 514(a)." (481 U.S. at 47).

But there is a dispute on that issue. That defendant was not an employee benefit plan, and any payment by the independent insurer would have no effect on the assets of the plan, so that could not have been the sort of claim Congress intended to preempt.

This Court recognized and corrected these errors in *De Buono*, as noted above, so that state tort and contract laws affecting all insurance plans, must be some of the "myriad state laws" of general applicability that may impose some burdens on the administration of ERISA plans, but nevertheless do not "relate to" them within the meaning of ERISA

And even the *Metropolitan Life* Court, 471 U.S. at 746, rejected an interpretation of the saving clause that saved from pre-emption "only state regulations unrelated to the substantive provisions of ERISA." Or, rephrased: "There may be some State insurance regulations which will be valid even if they relate to substantive provisions of ERISA."

So which are those provisions that are not preempted? They can only be those which apply to all insurers, and do not **conflict** with the substantive provisions of ERISA – for instance, additional remedies against non-plan, non-trustee defendants. There can be no conflict there, since ERISA has nothing to say about remedies against non-plan, non-trustee defendants.

Thus State laws affecting only insurers – and not plans – do not need to be saved by the 'savings' clause, since they do not 'relate to' a plan within the meaning of ERISA in the first instance.

6. INDIVIDUAL MEDICAL PROCEDURES ARE NOT BENEFITS OF AN INSURED BENEFIT PLAN, SO DENIAL SHOULD NOT BE LIMITED TO § 502 REMEDIES

ERISA comprehensively regulates, among other things, employee welfare benefit **plans** that, "through the purchase of insurance or otherwise," provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. § 3(1), 29 U.S.C. § 1002(1).

Thus, ERISA regulates **plans**, **not** insurers.

An insured plan has no clauses guaranteeing access to Vioxx, or specifying lengths of hospital stay, benefits at issue in the cases of Davila and Calad. Those are not benefits of the plan. Access to **individual medical procedures** are benefits of the insurance contract, subject to a plethora of conditions precedent specified within that contract, and traditionally interpreted according to State laws, none of which is within the control or expertise of the plan managers.

This source of frequent confusion and litigation would be greatly clarified if this Court simply declared definitively that when an employee benefit plan provides benefits by purchasing insurance, **it is only the insurance coverage itself which is the benefit of the plan**, the denial of which will subject the plan to the civil enforcement provisions of § 502. If the risk-bearing insurer subsequently denies particular benefits promised

under **the insurance policy**, the insurer is subject to State law in the same manner as it would be if it sold the same policy to a non-plan customer.

This is completely analogous to this Court's view of medical malpractice by a doctor referred to by a self-insured plan. The **referral** to the doctor is the benefit of the plan, subject to § 502. If the doctor fails to properly perform the procedure, he is subject to State negligence law in the same manner as he or any other doctor would be if the patient were not covered by ERISA. "[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." (*Pegram v. Herdrich*, 530 U.S. 211, 237 (2000)) And there has been no such manifestation.

This interpretation is most consistent with ERISA's dual intent of maximizing the ability of plan enrollees to enforce their rights, and not putting plan assets at excessive risk.

Since ERISA does not regulate insurance contracts, the Insurer's breach of the insurance contract should not be subject to the limitations of ERISA. Insurers are traditionally, and under ERISA, subject only to state laws and regulations and to the federal HMO Act, which has its own, quite mild, preemption provisions. Large bodies of State law have arisen expressly to deal with such insurance disputes, whereas the primary federal "remedy" appears to be F.R.C.P. 12(b)(6).

7. PLEAS FROM THE FEDERAL BENCH FOR REINTERPRETATION OF ERISA JURISPRUDENCE

Many Federal judges have railed against the injustices perpetrated on plan beneficiaries by the current interpretation of ERISA, and have urged that the rules be revised, even as they reluctantly enforced them. We agree with their views, except where they believe that this situation was the intent of Congress and only Congress can solve it. For the reasons raised above, the current situation is the antithesis of the Congressional intent,

and that it is well within the power of this Court to remedy the deplorable state into which employee welfare benefit plans have fallen.

Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822, 827 (1988):

> If the congressional intention were to immunize insurance companies from liability whenever they can show some arguable reason for their refusal to pay a claim, federal district courts should have already ordered the appropriate rubber stamps. If this court is looking in the mouth of the gift horse that would allow the court to abdicate is routine responsibility, it is because there are countervailing forces called "justice" and the Seventh Amendment's guarantee of a jury trial, both of where here give this court pause. There is [a] growing phalanx of courts expressing the fear that ERISA will continue to expand and to preempt everything in its meandering path.

Olson v. General Dynamics, 960 F.2d 1418, ¶27 (9th Cir. 1991), concurrence:

> I agree that ERISA preempts appellant's state law fraud claim, and that no federal or other remedy now exists for the wrongful conduct he alleges. Even if the defendants defrauded Olson . . . Olson may not assert the state cause of action he would have been entitled to plead prior to the enactment of ERISA. Because of the passage of ERISA, Olson is left without a remedy.
>
> Unfortunately, his fate is not unique. Congress enacted ERISA in 1974 in order to protect the rights of participants in private pension plans to a stable, secure source of retirement income. . . . [H]owever, **a statute designed to safeguard employee retirement benefits has, all to frequently, been used to deprive employees of rights they previously enjoyed** under state law while failing to provide any comparable

> federal remedy. The federal courts have routinely found state tort and implied contract remedies preempted by section 514(a) even when ERISA provides no substitute for the state cause of action.
>
> . . .
>
> The proliferation of ERISA preemption cases, in my view, raises a question as to whether **ERISA is having an effect that is substantially contrary to that intended** by those who favored its adoption.

Corcoran v. United Healthcare, 965 F.2d 1321, ¶¶65-67 (5th Cir. 1992):

> The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons.
>
> First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is **theoretically less deterrence of substandard medical decisionmaking**. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, **bad medical judgments will end up being cost-free** to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.
>
> Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. In a

prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would, at least in some circumstances, compensate the beneficiary who changes course based upon a wrong call for the costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

Finally, **cost containment features such as the one at issue in this case did not exist when Congress passed ERISA**. . . . Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees.

Cannon v. Group Health 77 F.3d 1270, ¶1 (10th Cir. 1996):

Although moved by the tragic circumstances of this case and the seemingly needless loss of life that resulted, we conclude the law gives us no choice but to affirm.

Dishman v. Unum, DC# CV-96-00015-JSL (C.D. CA 1997):

This case reveals that for benefit plans funded and administered by insurance companies, **there is no practical or legal deterrent to unscrupulous claims practices.** Without these practical incentives, there is no counter-balance to insurance companies' interest in minimizing ERISA claims . . . The fact that most people in Dishmans' situation would have had to capitulate is the most troubling aspect of this case. The need to deter insurance companies from behaving in this manner is why 'bad faith' liability exists under almost all state laws. ERISA preempts such laws. Under ERISA, no matter how unfounded the denial

of a claim may be, the only recover permitted to the claimant is the amount of the benefit. . . .

UNUM's **unscrupulous conduct** in this action **may be closer to the norm of insurance company practice than the Court has previously suspected**. . . . Absent . . . deterrents [to these unscrupulous claims practices], the bad faith denial of large claims, as a strategy for settling them for substantially less than the amount owed, may well become a common practice of insurance companies.

Andrews-Clarke v. Travelers Insur. Co., et al., 984 F. Supp. 49, 52 *et seq.* (1997):

[Defendants] promptly removed her case to this Court and then, just as promptly, asked this Court to throw her out without hearing the merits of her claim. This, of course, is ridiculous. The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief. . . .

Under the traditional notions of justice, the harms alleged – if true – should [mandate] some legal remedy . . . Consider just one of her claims – breach of contract. This cause of action – that contractual promises can be enforced in the courts – pre-dates Magna Carta. It is the very bedrock of our notion of individual autonomy and property rights. It was among the first precepts of the common law to be recognized in the courts of the Commonwealth and has been zealously guarded by the state judiciary from that day to this. Our entire capitalist structure depends on it. . . . [N]evertheless this court had no choice but to pluck [the] case out of state court in which she [his wife] sought redress and then, at the behest of Travelers, to slam the courthouse doors in her face and leave her without any remedy.

. . .

> Although the alleged conduct of [defendants] in this case in extraordinarily troubling, even more disturbing to this Court is the failure of Congress to amend a **statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent**. Does anyone care? Do you?

DeFelice v. Aetna, Third Circuit No. 02-3381 (10/15/2003), concurring opinion by Becker:

> I write separately to add my voice to the rising judicial chorus urging that Congress and the Supreme Court revisit what is **an unjust and increasingly tangled ERISA regime**. Congress enacted ERISA in 1974 "to promote the interest of employees and their beneficiaries in employee benefit plans.". . . .
>
> However, with the rise of managed care and the Supreme Court's series of decisions holding preempted any action for damages against HMOs, **ERISA has evolved into a shield that insulates HMOs from liability for even the most egregious acts of dereliction committed against plan beneficiaries**, a state of affairs that I view as directly contrary to the intent of Congress.
>
> Indeed, existing **ERISA jurisprudence creates a monetary incentive for HMOs to mistreat those beneficiaries**, who are often in the throes of medical crises and entirely unable to assert what meager rights they possess. Lower courts have struggled to maintain some semblance of equity notwithstanding the enormous breadth of the preemption test, one that turns on whether the claim is "related to" a benefit plan, *inter alia,* by identifying exceptions to § 514 preemption, such as that for medical malpractice liability. And in terms of the remedial scope of § 502,

> they have struggled to make sense out of the distinction between eligibility decisions (which are preempted) and medical decisions (which are not), a hopeless endeavor, as I shall explain.

Unfortunately, the price of all this has been descent into a Serbonian bog wherein judges are forced to don logical blinders and split the linguistic atom to decide even the most routine cases.

The underlying goal, purpose and intent of Congress in enacting ERISA has been undermind and misdirected with regard to insurer regulation. It is time to take a step back and reassess ERISA's language and structure in light of the statute's purpose. That reassessment must irrevocably result in the conclusion that state tort remedies against insurers who sell coverage to an ERISA plan are not preempted.

CONCLUSION

For the above reasons, amicus urges the Court to find that:

1. The ERISA benefit of an insured welfare benefit plan is the insurance coverage paid for by the plan, not the medical service paid for by the insurer under the insurance contract.

2. Only the plan's failure to provide the insurance coverage itself should be the violation which subjects the plan to the remedies of § 502(a).

3. The insurer's failure to pay for or provide specific medical service under the insurance contract subjects the insurer, but not the ERISA plan, to state contract and tort remedies.

4. Since the THCLA affects only insurers and not ERISA plans, it is not preempted by ERISA.

Respectfully submitted,

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